DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 96-015

2. STATE: MA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
Title XIX

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 1996 Except where otherwise noted

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 U.S.C. 1396r-4; 42 CFR 447

7. FEDERAL BUDGET IMPACT: 8,000 (in thousands
a. FFY 97 $ ~~0,500.00~~ see attached
b. FFY 98 $ ~~5,400.00~~ 19,000.

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19A(1)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same

10. SUBJECT OF AMENDMENT:
Acute Hospital Inpatient Payment System

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Not Required Under 45 CFR 204.1

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Bruce M. Bullen

13. TYPED NAME:
Bruce M. Bullen

14. TITLE:
Commissioner

15. DATE SUBMITTED:
December 27, 1996

16. RETURN TO:
Bridget Landers
State Plan coordinator
Division of Medical Assistance
600 Washington Street
Boston, MA 02111

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
12-31-96

18. DATE APPROVED: JUN 06 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
October 1, 1996 (see #4 above)

20. SIGNATURE OF REGIONAL OFFICIAL:
Dennis M. Mahoney for

21. TYPED NAME:
Ronald P. Preston

22. TITLE: (Ronald) Preston
Associate Regional Administrator, DMSO

23. REMARKS:

JUN 06 2001
OFFICIAL

FORM HCFA-179 (07-92)

Instructions on Back

INSTITUTIONAL STATE PLAN
ASSURANCE AND FINDING CERTIFICATION STATEMENT

STATE: Massachusetts
TN: 96-15

REIMBURSEMENT TYPE:

Inpatient hospital	x
Nursing facility	
ICF/MR	

PROPOSED EFFECTIVE DATES: October 1, 1996; October 19, 1996

A. *State Assurances and Findings.* The State assures that it has made the following findings:

1. *447.253(b)(1)(i) - The State pays for inpatient hospital services and long-term care facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable state and Federal laws, regulations, and quality and safety standards.* x

2. *With respect to inpatient hospital services --*

   a. *447.253(b)(1)(ii)(A) - The methods and standards used to determine payment rates take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs.* x

   b. *447.253(b)(1)(ii)(B) - If a State elects in its State plan to cover inappropriate level of care services (that is, services furnished to hospital inpatients who require a lower covered level of care such as skilled nursing services or intermediate care services, under conditions similar to those described in section 1861(v)(1)(G) of the Act, the methods and standards used to determine payment rates must specify that the payments for this type of care must be made at rates lower than those for inpatient hospital level of care services, reflecting the level of care actually received, in a manner consistent with section 1861(v)(1)(G) of the Act.*
   x

   If the answer is "not applicable," please indicate:

   ---

   c. *447.253(b)(1)(ii)(C) - The payment rates are adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality.* x

3. *With respect to nursing facility services --*

   a. *447.253(b)(1)(iii)(A) - Except for preadmission screening for individuals with mental illness and mental retardation under 42 CFR 483.20(f), the methods and standards used to determine payment rates take into account the costs of complying with the requirements of 42 CFR part 483 subpart B.* n/a

b. *447.253(b)(1)(iii)(B) - The methods and standards used to determine payment rates provide for an appropriate reduction to take into account the lower costs (if any) of the facility for nursing care under a waiver of the requirement in 42 CFR 483.30(c) to provide licensed nurses on a 24-hour basis.*

n/a

c. *447.253(b)(1)(iii)(C) - The State has established procedures under which the data and methodology used to establish payment rates are made available to the public.* n/a

4. *447.253(b)(2) - The proposed payment rate will not exceed the upper payment limits as specified in 42 CFR 447.272:*

a. *447.272(a) - Aggregate payments to each group of health care facilities (hospitals, nursing facilities, and ICFs/MR) will not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles.*

x

b. *447.272(b) - Aggregate payments to each group of State-operated facilities (that is, hospitals, nursing facilities, and ICFs/MR) -- when considered separately -- will not exceed the amount that can reasonably be estimated would have been paid for under Medicare payment principles.* x

If there are no State-operated facilities, please indicate "not applicable:"

c. *447.272(c) - Aggregate disproportionate share hospital (DSH) payments do not exceed the DSH payment limits at 42 CFR 447.296 through 447.299.* x

d. *Section 1923(g) - DSH payments to individual providers will not exceed the hospital-specific DSH limits in section 1923(g) of the Act.* x

B. <u>State Assurances</u>. *The State makes the following additional assurances:*

1. *For hospitals --*

a. *447.253(c) - In determining payment when there has been a sale or transfer of the assets of a hospital, the State's methods and standards provide that payment rates can reasonably be expected not to increase in the aggregate solely as a result of changes of ownership, more than payments would increase under Medicare under 42 CFR 413.130, 413.134, 413.153 and 413.157 insofar as these sections affect payment for depreciation, interest on capital indebtedness, return on equity (if applicable, acquisition costs for which payments were previously made to prior owners, and the recapture of depreciation.* x

2. *For nursing facilities and ICFs/MR--*

   a. *447.253(d)(1) - When there has been a sale or transfer of the assets of a NF or ICF/MR on or after July 18, 1984 but before October 1, 1985, the State's methods and standards provide that payment rates can reasonably be expected not to increase in the aggregate, solely as a result of a change in ownership, more than payments would increase under Medicare under 42 CFR 413.130, 413.134, 413.153 and 413.157 insofar as these sections affect payment for depreciation, interest on capital indebtedness, return on equity (if applicable), acquisition costs for which payments were previously made to prior owners, and the recapture of depreciation.* n/a

   b. *447.253(d)(2) - When there has been a sale or transfer of the assets of a NF or ICF/MR on or after October 1, 1985, the State's methods and standards provide that the valuation of capital assets for purposes of determining payment rates will not increase (as measured from the date of acquisition by the seller to the date of the change of ownership) solely as a result of a change of ownership, by more than the lesser of:*

   (i) 1/2 of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership) in the Dodge construction index applied in the aggregate with respect to those facilities that have undergone a change of ownership during the fiscal year; or

   (ii) 1/2 of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership) in the Consumer Price Index for All Urban Consumers (CPI-U) (United States city average) applied in the aggregate with respect to those facilities that have undergone a change of ownership during the fiscal year. n/a

3. *447.253(e) - The State provides for an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the State determines appropriate, of payment rates.* x

4. *447.253(f) - The State requires the filing of uniform cost reports by each participating provider.* x

5. *447.253(g) - The State provides for periodic audits of the financial and statistical records of participating providers.* x

6. *447.253(h) - The State has complied with the public notice requirements of 42 CFR 447.205.*

Notices published on: 8/23/96; 10/18/96

If no date is shown, please explain: _____

7. *447.253(i) - The State pays for inpatient hospital and long-term care services using rates determined in accordance with the methods and standards specified in the approved State plan.* x

C. *Related Information*

1. *447.255(a) - NOTE: If this plan amendment affects more than one type of provider (e.g., hospital, NF, and ICF/MR; or DSH payments) provide the following rate information for each provider type, or the DSH payments. You may attach supplemental pages as necessary.*

Provider Type: Inpatient Acute Hospital

For hospitals: Include DSH payments in the estimated average rates. You may either combine hospital and DSH payments or show DSH separately. If including DSH payments in a combined rate, please initial that DSH payment are included. DSH payments not included
Estimated average proposed payment rate as a result of this amendment: see attached
Average payment rate in effect for the immediately preceding rate period: see attached
Amount of change: see attached
Percentage of change: see attached

2. *447.255(b) - Provide an estimate of the short-term and, to the extent feasible, long-term effect the change in the estimated average rate will have on:*

(a) *The availability of services on a statewide and geographic area basis:* no effect

(b) *The type of care furnished:* no effect

(c) *The extent of provider participation:* no effect

State MA
TN 96-15

(d) For hospitals -- the degree to which costs are covered in hospitals that serve a disproportionate number of low income patients with special needs: no effect

I HEREBY CERTIFY that to the best of my knowledge and belief, the information provided is true, correct, and a complete statement prepared in accordance with applicable instructions.

Completed by Lisa MacDonough Date 12-30-96
Title: Senior Reimbursement Analyst
Division of Medical Assistance

447.255(a) - Related Information

	Estimated Average Acute Per Diem	Projected Annual Disproportionate Share Hospital Payments
RY96: 10/1/95-9/30/96	$819.55	$391.0 M
RY97: 10/1/96-10/18/96	823.10	400.0 M
Dollar Change:	+ 3.55	+9.0 M
Percentage Change:	+0.43%	+2.3%

	Estimated Average Acute Per Diem	Projected Annual Disproportionate Share Hospital Payments
RY97: 10/1/96-10/18/96	$823.10	$400.0 M
RY97: 10/19/96-9/30/97	836.72	393.0 M
Difference:	+ 13.62	-7.0 M
Difference:	+ 1.65%	-1.8%

Estimated Acute Hospital Rate Year 1997/1998 Impact

Federal Fiscal Years 1997 and 1998

	FFY 1996	FFY 1997	Change	FFY 1998	Change	Total FFY 97 Impact	Federal Share FFY 97 Impact	Total FFY 98 Impact	Federal Share FFY 98 Impact
1. Medicaid Payments in millions	$350.0	$357.1	2.00%	$367.8	3.00%	$7.0	$3.5	$10.7	$5.4
2. Medicaid Days	427,064	427,064	0.00%	427,064	0.00%				
3. Medicaid per Diem	$819.55	$836.05	2.00%	$861.13	3.00%	$16.50	$8.25	$25.08	$12.54
4. Disproportionate Share Payments in millions	$391.0	$400.0	2.30%	$393.0	-1.75%	$9.0	$4.5	($7.0)	($3.5)
5. Total Payments (Line 1 + Line 4) in millions	$741.0	$757.1	2.17%	$760.8	0.49%	$16.0	$8.0	$3.7	$1.9

State Plan Under Title XIX of the Social Security Act
State: Massachusetts
Institutional Reimbursement

Methods Used to Determine Rates of Payment for Acute Inpatient Hospital Services

I: OVERVIEW

On August 6, 1996, the Division of Medical Assistance of the Executive Office of Health and Human Services (hereafter referred to as "the Division") issued the Medicaid program's sixth Request for Application (RFA) to solicit applications from eligible, in-state acute hospitals which seek to participate as Medicaid providers of acute hospital services. The goal of the RFA was to enter into contracts with all eligible, acute hospitals in Massachusetts which accept the method of reimbursement set forth below as payment in full for providing Medicaid recipients with the same level of clinical services as is currently provided by those hospitals and their hospital-licensed health centers. In-state acute hospitals which: (1) operate under a hospital license issued by the Massachusetts Department of Public Health (DPH); (2) participate in the Medicare program; (3) have more than fifty percent (50%) of their beds licensed as medical/surgical, intensive care, coronary care, burn, pediatric, pediatric intensive care, maternal (obstetrics) or neonatal intensive care beds, as determined by DPH; and (4) currently utilize more than fifty (50%) of their beds as such, as determined by the Division, are eligible to apply for a contract pursuant to the RFA.

An Applicant's Conference was held on August 19, 1996, at which time interested parties could ask questions to clarify any aspect of the methodology. Written questions and comments were accepted through August 20, 1996. The RFA and its methodology became effective October 1, 1996. All eligible acute hospitals are participating providers.

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II: DEFINITIONS

Administrative Day (AD) - A day of inpatient hospitalization on which a recipient's care needs can be provided in a setting other than an acute inpatient hospital, and on which the recipient is clinically ready for discharge, but an appropriate institutional or non-institutional setting is not readily available. See 130 CMR 415.415 and 415.416 attached as **Exhibit 1.**

Administrative Day Per Diem - An all-inclusive per diem payable to hospitals for administrative days.

Clinical Laboratory Service - Microbiological, serological, chemical, hematological, biophysical, radioimmunoassay, cytological, immunological, pathological, or other examinations of materials derived from the human body to provide information for the assessment of a medical condition or for the diagnosis, prevention, or treatment of any disease.

Community-Based Physician - Any physician, excluding interns, residents, fellows, and house officers, who is not a hospital-based physician. For purposes of this definition and related provisions, the term physician includes dentists, podiatrists, and osteopaths.

Contract (Hospital Contract or Agreement) - The agreement executed between each selected hospital and the Division which incorporates all of the provisions of the RFA.

Contractor - Each hospital that is selected by the Division after submitting a satisfactory application in response to the RFA and that enters into a contract with the Division to meet the purposes specified in the RFA.

Distinct Part Psychiatric Unit (DPU) - An acute hospital's psychiatric unit that meets all requirements of 42 C.F.R. Part 412.

Division - The Commonwealth of Massachusetts, Executive Office of Health and Human Services, Division of Medical Assistance.

Division of Health Care Finance and Policy (DHCFP) - a Division of the Commonwealth of Massachusetts, Executive Office of Health and Human Services. DHCFP performs many of the functions performed by the former Rate Setting Commission and former Division of Medical Security.

Gross Patient Service Revenue - The total dollar amount of a hospital's charges for services rendered in a fiscal year.

Health Maintenance Organization (HMO) - An entity approved by the Massachusetts Division of Insurance to operate under M.G.L. c.176G.

Hospital - Any hospital licensed under M.G.L. c.111 §51 (and the teaching hospital of the University of Massachusetts Medical School), and which meets the eligibility criteria set forth in Section I.

Hospital-Based Entity - Any entity which contracts with a hospital to provide medical services to recipients on the same site as the hospital's inpatient facility.

Hospital-Based Physician - Any physician, excluding interns, residents, fellows, and house officers, who contracts with a hospital or hospital-based entity to provide services to recipients, on the same site as the hospital's inpatient facility. For purposes of this definition and related provisions, the term physician includes dentists, podiatrists, and osteopaths.

Hospital-Specific Standard Payment Amount Per Discharge (SPAD) - An all-inclusive payment for the first twenty cumulative acute days of an inpatient hospitalization, which is complete reimbursement for an acute episode of illness, excluding the additional payment of Outliers, Transfer per Diems, and Administratively Necessary Days.

Inpatient Services - Services reimbursable by the Division pursuant to the RFA which are provided to recipients admitted as patients to a hospital.

Managed Care Organization (MCO) - the managed care organization with which the Division contracts to administer the Division's Mental Health and Substance Abuse Program (MH/SAP).

Medicaid - The Medical Assistance Program administered by the Division to furnish and pay for medical services pursuant to the Massachusetts Medicaid Statute and Title XIX of the Social Security Act.

Mental Health/ Substance Abuse Program - a managed care program for the provision of mental health and substance abuse services to Medicaid recipients enrolled in the program.

Outlier Day - Each day during which a recipient remains hospitalized at acute (non-psychiatric) status beyond twenty acute days during the same, single admission. AD days occurring within the period of hospitalization are not counted toward the outlier threshold as described in Section IV.B.8.

Pass-Through Costs - Organ acquisition and malpractice costs that are paid on a cost-reimbursement basis and are added to the hospital-specific standard payment amount.

Pediatric Specialty Hospital - An acute hospital which limits admissions primarily to children and which qualifies as exempt from the Medicare prospective payment system regulations.

Pediatric Specialty Unit - A pediatric unit in an acute hospital in which the ratio of licensed pediatric beds to total licensed hospital beds as of July 1,

1994 exceeds 0.20, unless located in a facility already designated as a specialty hospital.

Primary Care Clinician Program (PCCP) - a comprehensive managed care program with primary care clinicians managing enrolled recipients' medical care.

Public Service Hospital - Any public acute hospital or any acute hospital operating pursuant to Chapter 147 of the Acts & Resolves of 1995 (see attached Exhibit 2) which has a private sector payer mix that constitutes less than twenty-five percent (25%) of its gross patient service revenue (GPSR) and where uncompensated care comprises more than twenty percent (20%) of its GPSR.

Rate Year (RY) - The period beginning October 1 and ending September 30. For example, RY97 will begin on October 1, 1996 and end on September 30, 1997.

Recipient - A person determined by the Division to be eligible for medical assistance under the Medicaid program.

Sole Community Hospital - Any acute hospital classified as a sole community hospital by the U.S. Health Care Financing Administration's Medicare regulations, or any hospital which demonstrates to the Division of Health Care Finance and Policy's satisfaction, that it is located more than 25 miles from other acute hospitals in the Commonwealth and which provides services for at least sixty percent of their primary service area.

Specialty Hospital - Any acute hospital which limits admissions to children or to patients under active diagnosis and treatment of eyes, ears, nose, and throat, or diagnosis and treatment of cancer and which qualifies as exempt from the Medicare prospective payment system regulations.

Transfer Patient - Any patient who meets any of the following criteria: 1) transferred between acute hospitals; 2) transferred between a distinct part psychiatric unit and a medical/surgical unit in an acute hospital; 3) receiving substance abuse-related services whose status in the MH/SAP changes; or 4) who becomes eligible for Medicaid after the date of admission and prior to the date of discharge.

Upper Limit - The term referring to the level below which it is determined that the hospital reimbursement methodology will result in payments for hospital services in the aggregate that are no more than the amount that would be paid under Medicare principles of reimbursement.

Usual and Customary Charges - Routine fees hospitals charge for acute inpatient services rendered to patients regardless of payor source.

III: NON-COVERED SERVICES

The Division will reimburse Medicaid participating hospitals at the rates established in the RFA for all acute inpatient services provided to Medicaid recipients except for the following:

A. Mental Health and Substance Abuse Services for Recipients Assigned to the MH/SAP

The MCO contracts with a provider network to deliver mental health and substance abuse services for Medicaid recipients assigned to the MH/SAP. Hospitals in the MCO's network are paid by the MCO for services to recipients assigned to the MH/SAP, pursuant to the contract between the MCO and the hospital.

Hospitals that are not in the network (hereinafter "non-network hospitals") do not qualify for Medicaid reimbursement for recipients assigned to the MH/SAP seeking mental health or substance abuse non-emergent care, except in accordance with a service-specific agreement with the MCO.

Non-network hospitals that provide medically necessary mental health and substance abuse emergent care to MH/SAP assigned recipients qualify for reimbursement by the MCO.

Hospitals may not bill the Division, and the Division will not reimburse hospitals for mental health and substance abuse services provided to MH/SAP assigned recipients.

B. HMO Services

Hospitals providing services to Medicaid recipients enrolled in HMOs will be reimbursed by HMOs for those services.

Hospitals may not bill the Division, and the Division will not reimburse hospitals for services provided to Medicaid recipients enrolled in an HMO where such services are covered by the HMO's contract with the Division. Furthermore, hospitals may not "balance bill" the Division for any services covered by the HMO's contract with the Division. HMO reimbursements shall be considered payment in full for any HMO-covered services provided to a Medicaid recipient enrolled in an HMO.

C. Air Ambulance Services

In order to receive reimbursement for air ambulance services, providers must have a separate contract with the Division for such services.

D. Hospital Services Reimbursed through Other Contracts or Regulations

The Commonwealth may institute special program initiatives other than those listed above which provide, through contract and/or regulation, alternative reimbursement methodologies for hospital services or certain hospital services. In such cases, payment for such services is made pursuant to the contract and/or regulations governing the special program initiative, and not through the RFA and resulting contract.

State Plan Under Title XIX of the Social Security Act
State: Massachusetts
Institutional Reimbursement

IV: REIMBURSEMENT SYSTEM

A. DATA SOURCES

In the development of each hospital's RY97 standard payment amount per discharge (SPAD), the Division used Medicaid audited paid claims for the period June 1, 1995 to May 31, 1996; the FY95 RSC-403 report, as submitted to the Rate Setting Commission n/k/a DHCFP; and the RY95 Merged Casemix/ Billing Tapes, as accepted by the Rate Setting Commission, as the primary sources of data to develop base operating costs. The wage area adjustment was derived from the 1993 Medicare 2552 Cost Report.

B. METHODOLOGY FOR INPATIENT SERVICES

1. Overview

Payments for inpatient services, other than for psychiatric services provided in distinct part psychiatric units, will consist of the sum of 1) a statewide average payment amount per discharge that is adjusted for wage area differences and the hospital-specific Medicaid casemix; 2) a per discharge, hospital-specific payment amount for hospital-specific expenses for malpractice and organ acquisition costs; 3) a per discharge, hospital-specific payment amount for direct medical education costs which includes a primary care training incentive and a specialty care reduction; and 4) a per discharge, hospital-specific payment amount for the capital cost allowance, adjusted by hospital-specific casemix. Each of these elements is described in Sections IV.B.2 through IV.B.5. The statewide average payment amount per discharge incorporates an efficiency standard.

Payment for psychiatric services provided in distinct part psychiatric units to Medicaid patients who are not served either through a contract between the Division and its MH/SAP MCO or an HMO shall be made through an all-inclusive regional weighted average per diem, updated for inflation and adjusted to reflect any reductions negotiated by the hospital and the Division's MH/SAP MCO (described in Section IV.B.7).

Payment for physician services rendered by hospital-based physicians will be made as described in Section IV.B.10.

2. Hospital-Specific Standard Payment Amount Per Discharge (SPAD)

a. Calculation

The statewide average payment amount per discharge is based on the actual statewide costs of providing inpatient services in FY95. The average cost per discharge for FY95 was determined

using the FY95 DHCFP Merged Billing and Discharge Data and the FY95 RSC-403, as screened and updated as of June 20, 1996. Cost and utilization data for the following were excluded in calculation of the statewide average payment amount per discharge; hospitals and hospital units with unique circumstances, as set forth in Sections IV.C.1-IV.C.4; and psychiatric units.

The average cost per discharge in each hospital was derived by dividing total hospital costs by total hospital discharges, excluding those from psychiatric, chronic or observation units, or skilled nursing facilities. Costs associated with distinct part psychiatric units, chronic units, SNF units, and observation units were excluded. The cost centers which are identified as the supervision component of physician compensation and other direct physician costs were included; professional services were excluded. All other medical and non-medical staff expenses were included.

Malpractice, organ acquisition, capital, and direct medical education costs were excluded from the calculation of the statewide average payment amount.

The average cost per discharge for each hospital was then divided by the hospital's Massachusetts-specific wage area index and by the hospital-specific FY95 all-payer casemix index using the Version 12.0 New York grouper and New York weights. (For the non-exempt Massachusetts hospitals in the areas designated by the Geographical Classification Review Board of the Health Care Financing Administration, effective September 1, 1995, the average hourly wage of each area was calculated from audited FY93 Medicare 2552 Cost Reports. Each area's average hourly wage was then divided by the statewide average hourly wage to determine the area's wage index. For the calculation of the Springfield area index, the Baystate Medical Center's wages and hours were included). This step results in the calculation of the standardized Medicaid costs per discharge for each hospital. These standardized costs per discharge were compared to the standardized Medicaid costs per discharge from the RY96 RFA with three years of inflation. If the RY96 standardized Medicaid cost per discharge was at least 15% more than the standardized cost per discharge calculated in RY97, the standardized costs per discharge were capped at 15% over the RY96 Medicaid costs per discharge.

The hospitals were then ranked from lowest to highest with respect to their standardized costs per discharge; a cumulative frequency of Medicaid discharges for the hospitals was produced; and an efficiency standard was established as the weighted median cost per discharge. The RY97 efficiency

standard was established as the cost per discharge corresponding to the discharge located at the seventy-fifth percentile; this means that 75% of the Medicaid caseload was treated in hospitals whose operating costs were recognized in full. The RY97 efficiency standard is $2,938.34. The weighted seventy-fifth percentile is the highest standardized cost per discharge that will be recognized for any individual hospital in the computation of the statewide average payment amount.

The RY97 statewide average payment amount per discharge was then determined by multiplying a) the weighted mean of the standardized cost per discharge, as limited by the efficiency standard; by b) the outlier adjustment factor of ninety-five percent (95%); by c) an inflation factor of 3.16% which reflects price change between RY95 and RY96; and by d) an inflation factor of 2.38% which reflects price changes between RY96 and RY97. Each inflation factor is a blend of the HCFA market basket and the Massachusetts Consumer Price Index (CPI). Specifically, the CPI replaces the labor-related component of the HCFA market basket to reflect conditions in the Massachusetts economy. The resulting statewide average payment amount per discharge is $2,622.08.

The statewide average payment amount per discharge was then multiplied by the hospital's Medicaid casemix index (using version 12.0 of the New York Grouper and New York weights) and the hospital's Massachusetts specific wage area index to derive the hospital-specific standard payment amount per discharge (SPAD). The wage area indexes were derived from audited FY93 Medicare Cost Reports (2552).

The outlier adjustment is used for the payment of outlier days as described in Section IV.B.8.

The RY98 statewide average payment amount per discharge will be calculated as described above, except for the addition of an update factor to reflect price changes between RY97 and RY98.

When groupers are changes and modernized, it is necessary to adjust base payment rates so that overall payment levels are not affected solely by the grouper change. This aspect of "budget neutrality" is an approach that the Division is following, and one that has been a feature of the Medicare DRG program since its inception. The Division reserves the right to update to the new grouper should there be a grouper developed during the next rate year.